Managed Care Organizations in Oregon Workers' Compensation
Background

What is an MCO?
A managed care organization (MCO) contracts with insurers or self-insured employers to provide managed health care services to workers enrolled in the MCO. MCOs focus specifically on treating injured workers. These health care services are provided through participating panel providers.

The director of the Department of Consumer and Business Services must certify MCOs. The director cannot certify an organization that is formed, owned, or operated by an insurer or employer. MCOs were created during the 1990s Mahonia Hall workers' compensation reforms. The director has certified many MCOs since then. However, today only four remain: CareMark Comp/Managed Healthcare Northwest (MHN); Kaiser On-the-Job; Majoris Health Systems Oregon, Inc.; and Providence MCO.

Why were MCOs created?
The 1990 legislative reforms created MCOs. The reasons cited for creating managed care, as outlined in the MLAC Mahonia Hall report, were:

- For workers: [to provide] "managed medical care system to deliver high quality and consistent standard of medical service to all workers."
- For employers, "managed medical care system controls costs while delivering high quality and consistent standard of medical care, with unnecessary care eliminated."

How do MCOs work?
Workers may be enrolled in an MCO if they have filed a workers' compensation claim and the worker's employer is covered by an insurer that has a contract with an MCO. If enrolled, a worker must treat with an MCO panel provider, although there are some exceptions. MCOs may only provide services in those geographic service areas that are authorized by the director. MCOs have the authority to designate any medical service provider or category of providers as attending physicians.

MCOs recruit medical providers for their panels and perform peer review of panel members. The MCOs require precertification of many services to ensure quality of medical services. They also provide dispute resolution services for workers, providers, and insurers.

What are MCO enrollment requirements?
Insurers and self-insured employers determine whether and when to enroll workers into a contracted MCO. Many insurers enroll workers at the time of claim acceptance. Others automatically enroll workers upon notice or knowledge of the claim. Overall, just under half of workers with accepted disabling claims are enrolled in an MCO.

The insurer or the self-insured employer must send a written enrollment notice to the worker, as well as provide copies to the worker's attorney (if represented); all the worker's medical service providers; and to the MCO. Enrollment notices generally direct workers to the MCO website, where they can find a list of available MCO panel providers. MCOs must help workers who have questions about the process; difficulty getting a new attending physician; or treatment disputes.

Enrollment figures for recent years are on the last page of this overview.

Who may provide treatment to enrolled workers?
Medical providers contract with MCOs to be members of their provider panel. Each MCO sets criteria for who may be a panel provider. Enrolled workers are required to treat with an MCO panel provider. However, if the worker has been treating with a provider they may be able to continue treatment with the non-MCO provider if certain criteria are met.

What medical services are allowed?
MCOs may require precertification, or pre-approval, for certain medical services. This may include elective surgeries, physical medicine services, and diagnostic services. Specific requirements for precertification vary among the four certified MCOs.

How are disputes resolved?
If the MCO does not grant approval of a medical service, the worker or provider may request review, usually through the MCO's internal dispute resolution process. If there is still disagreement, the decision can be appealed to the Workers' Compensation Division. An insurer also has the right to request review of an MCO decision approving a precertification request.

Workers' Compensation Division - disputes related to Managed Care Organizations

	2016 Total	Affirmed*	% affirmed	2017 Total	Affirmed*	% affirmed
CareMark Comp / MHN	55	34	62%	63	40	63%
Providence	8	4	50%	7	4	57%
Majoris	68	43	63%	80	50	63%
Kaiser OTJ	2	2	100%	3	0	0%
TOTAL	**133**	**83**	62%	**153**	**94**	61%

* Affirmed means the full MCO decision was upheld

Number of Accepted Disabling Claims Enrolled in Managed Care

Claims Data by Insurer and MCO

2018	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11381	7011	1576	0	4682	753
Private Insurers	5533	614	4	420	190	0
Self-Insured Employers	3950	1742	222	784	283	453
NCE / Sedgwick	48	0	0	0	0	0
Total	20912	9367	1802	1204	5155	1206
		44.80%				

2017	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11167	7387	1987	0	4719	681
Private Insurers	5570	558	1	390	167	0
Self-Insured Employers	4115	1881	169	1036	254	422
NCE / Sedgwick	44	0	0	0	0	0
Total	20896	9826	2157	1426	5140	1103
		47.02%				

2016	Accepted Disabling Claims	Total MCO Enrolled Claims	CareMark Comp/MHN	Providence	Majoris	Kaiser OTJ
SAIF	11089	7381	2172	0	4489	720
Private Insurers	5184	501	3	359	137	2
Self-Insured Employers	4045	1727	140	1009	130	448
NCE / Sedgwick	45	0	0	0	0	0
Total	20363	9609	2315	1368	4756	1170
		47.19%				